STATE OF MONTANA and MONTANA UNIVERSITY SYSTEM

ANALYSIS AND EVALUATION OF CLAIMS PROCESSING FOR THE PERIOD JANUARY 1, 2000 THROUGH DECEMBER 31, 2001

Prepared Under Contract With:
MONTANA LEGISLATIVE BRANCH, AUDIT DIVISION
PO Box 201705, Helena, MT 59620-1705

STATE OF MONTANA and
MONTANA UNIVERSITY SYSTEM

ANALYSIS AND EVALUATION OF
CLAIMS PROCESSING
FOR THE PERIOD
JANUARY 1, 2000 THROUGH DECEMBER 31, 2001

ADMINISTERED BY

BLUE CROSS BLUE SHIELD OF MONTANA

FINAL REPORT

APRIL, 2002

PRESENTED BY

WOLCOTT & ASSOCIATES, INC.
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LEGISLATIVE AUDIT DIVISION

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March 2002

The Legislative Audit Committee
of the Montana State Legislature:

Enclosed is the report on the special purpose audit of Montana Employee Benefit Plan, administered by the Department of Administration, and the Montana University System Benefit Plan, administered by the Office of the Commissioner of Higher Education, for the two calendar years ended December 31, 2001.

The audit was conducted by Wolcott & Associates, Inc., under a contract between the firm and our office. The comments and recommendations contained in this report represent the views of the firm and not necessarily the Legislative Auditor.

The agency's written response to the report recommendations is included in the back of the audit report

Respectfully submitted,

Scott A. Seacat
Legislative Auditor

02C-08

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STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
HEALTH CARE PLAN AUDIT
OF BLUE CROSS BLUE SHIELD OF MONTANA
JANUARY 1, 2000 - DECEMBER 31, 2001

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I - INTRODUCTION

The State of Montana (State) provides self-funded medical care and dental care benefits as part of an overall employee benefit and compensation program. The plan covers approximately 14,000 employees and retirees, plus their dependents.

The State has negotiated a contract with Blue Cross Blue Shield of Montana (BCBSMT) to provide administration services to its plans.

The Montana University System (MUS) is a member of the Montana Association of Health Care Purchasers, and has also contracted to have their medical and dental care benefits administered by BCBSMT.

The State invited MUS to participate in an audit of BCBSMT's processing of medical care and dental care claims.

PURPOSE OF SERVICE

Section 2.18.816, MCA requires the State Employee Benefits Plan to be audited every two years by or at the direction of the Legislative Audit Division. Wolcott & Associates, Inc. was awarded the audit contract for the 1998-1999 Plan Years with an option, by the State, to renew the contract with Wolcott & Associates, Inc.

The purpose of the service is to comply with Section 2.18.816, MCA.

The State and MUS recognize that they have a fiduciary responsibility to administer this plan (and other employee benefit plans) for the benefit of plan participants and their dependents and in accordance with the plan provisions. Both plan sponsors believe it is prudent to perform periodic audit and review services to determine if the benefit plans they sponsor are meeting these objectives.

AUDIT TIMING AND STAFF

The Legislative Audit Division advised Wolcott & Associates, Inc. that the audit contract had been renewed on December 4, 2001. All preliminary work was completed and the entrance meeting was held in Helena on February 25, 2002. On-site work at the State, MUS, and BCBSMT was performed during the week of February 25, 2002.

On-site audit services were performed at:

State of Montana
State Personnel Division
Mitchell Building
Helena, Montana 59620

Montana University System
2500 Broadway
Helena, Montana 59620

Blue Cross & Blue Shield of Montana
560 North Park Avenue
Helena, Montana 59601

Wolcott & Associates, Inc. staff involved in the audit are listed below:

Name	Title	On-site
Brian Wyman	Manager	Yes
Marie Pollock	Vice President, Project Director	Yes
Richard Reese	Actuary	No
Sue Tarr	Vice President	Yes
Jenny Huigens	Auditor	Yes

SCOPE OF AUDIT

The scope of audit services covered medical care and dental care benefit claims paid by BCBSMT during the period from January 1, 2000 through December 31, 2001. Test work was performed on 600 previously processed claims, all of which were selected on a stratified, random (statistical) basis.

Claims Adjudication Audit

Elements of claims adjudication which were evaluated include:

- Turnaround time required to process each claim.
- Eligibility of claimants to receive payment.
- Positive confirmations of individual payments with the plan's employees.
- Administration of coordination of benefits, including Medicare.

- Administration of subrogation provisions.
- Calculation accuracy, including Usual, Customary and Reasonable (UCR) limits and computation of deductible and co-payment limits.
- Completeness of necessary information.
- Payee accuracy, including benefit assignments to service providers.
- Consistency of payments to BCBSMT member physicians and other physicians.
- Compliance with benefit plan structure.
- Identification of duplicate claim submissions.

Test Claims

Test claims were prepared and entered into the BCBSMT system to test various aspects of the system's capabilities. The test claims addressed the following:

- Duplicate claims.
- Duplicate claim logic.
- Claims for terminated individuals.
- Claims for terminated dependents.
- Claims from a fictitious provider.
- Claims for fictitious services.
- Claims involving coordination of benefits with another health care plan.
- Claims involving fees in excess of the usual, customary and reasonable limit established for the plan.
- Claims for procedures and/or diagnosis codes that are inconsistent with the patient's sex.

II - STATISTICAL CLAIM AUDIT RESULTS

The results of our audit of previously processed claims are presented in this section.

SAMPLE SIZE AND METHODOLOGY

The proposal request stated that our sample size was to be large enough so as to express the frequency of error with a 95% confidence and a precision of + or - 3%, assuming an error rate of 5% or less. As a result, we proposed to audit a sample of 600 claims.

The claims were selected from the population of claims paid by BCBSMT between January 1, 2000 and December 31, 2001. Prior to selection, the population of claims was stratified.

AUDIT PROCEDURE

Information presented below describes our test work on the 600 previously processed claims in our sample and the errors identified. The test involved the following:

- Review of previously processed claims to determine if selected claim is a duplicate of a previously processed claim.
- Review of member specific coverage on BCBSMT's records to the coverage indicated on the plan's records.
- Verification that members are employees/retirees of the plan and covered under the plan at the time the claim was incurred.
- Review to determine that BCBSMT is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.

- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.

- Review of the microfilm copies and source documents, when appropriate, to determine if there are any indications of fraud.

DEFINITION OF ERROR

We defined an error to be any claim where the payment to the participant or the provider did not agree with the plan document provisions.

AUDIT RESULTS

Of the 600 claims in our statistical sample, 7 were judged to contain a payment error. This represents a frequency of payment error of 1.2%. Of these 7 claims, 5 were overpayments and 2 were underpayments.

Our sample contained a total payment of $7,109,991 for the 600 claims. The overpayments totaled $26,634.67 or 0.37% of the total. The underpayments totaled $68.53 or 0.001% of the total.

The frequency of payment error in our sample is below the three to five percent error rate normally observed during our audits of similar plans. It is also below the BCBSMT standard of 3%. The error rate is also below the 1.9% error rate reported in the prior audit report.

POPULATION DATA

Our sample was selected on a stratified basis. The basis for stratification was paid amount. This sampling method can be expected to produce sample results that differ from the results projected for the population.

We have extended the results of our sample to the population of claims paid during the audit period.

Based on this extension, we are 95% confident with a precision of + or - 1.1%, that the true frequency of error in the population is within the range of 0.2% to 2.4%.

Based on this extension, we believe that the true magnitude of payment error in the population is $108,035 or (0.09%). The magnitude of payment error is the sum of $88,905 in

projected overpayments plus $19,130 in projected underpayments.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit A**. A discussion of error types is presented below.

Four of the errors involved incorrect data entry.

Two of the errors involved large claims that were incorrectly "split" causing the payment errors.

One error involved the application of the $15 co-pay when the patient goes to more than one doctor per day.

A summary of error by type is presented below:

BCBSMT HEALTH CARE CLAIMS
JANUARY 1, 2000 THROUGH DECEMBER 31, 2001
SUMMARY OF ERRORS BY TYPE

ERROR TYPE	NUMBER	NET PAYMENT ERROR
Data entry errors	4	$ (31.63) net
Incorrectly split claim and did not apply discount.	1	169.84
Incorrectly split claim and did apply correct LCM contract	1	26,412.93
Should have applied OV co-pay on multiple visits to providers.	1	15.00
Total	7	$26,409.18

BCBSMT has included their response as **Exhibit D**.

LIFETIME MAXIMUM

The State's plan document contains a provision for a $1,000,000 lifetime maximum. The State requested that we review BCBSMT's procedures for calculating and monitoring the lifetime maximum provision.

BCBSMT's system coding for accumulating the lifetime maximum does not include claims that have been archived. Archived claims are older claims that are not included in the 16 categories BCBSMT uses for determining if a claim should be archived. However, the Special Accounts Liaison manually monitors specific patients when utilization is substantially high. The Special Accounts Liaison orders reports, which include the archived claims, and from those reports they monitor the accumulation towards the lifetime maximum benefit.

BCBSMT provided us with a report of one participant who had exceeded the lifetime maximum, in order to verify the system was appropriately calculating the lifetime maximum benefit. BCBSMT, at our request, performed a test of the system by processing a claim that would exceed the lifetime maximum. No exceptions were noted during this test.

III - PARTICIPANT CONFIRMATIONS

Our work plan included the preparation and mailing of 239 confirmations to participants who had received medical or dental services under the plan. The results are discussed below.

The address for each claimant was obtained from the plan sponsor and/or BCBSMT claim system. A letter, requesting confirmation of the medical or dental services, was mailed to each.

We received 166 responses to our initial confirmation request. Contact by telephone was made to the participants who did not respond to the initial confirmation. We also requested the assistance of the plan sponsors in contacting the participants.

All but 73 of the 239 participants eventually responded.

Of those that responded, all but 2 confirmed that the services were received. Each of the 2 that did not agree with BCBSMT records are discussed below.

- One participant reported not having her records available due to being away for the winter, but thought that the services were rendered by the stated physician. We contacted the physician and they confirmed the services.

- One participant reported not having services rendered by the stated physician. We contacted the physician and their records confirmed they saw the participant on that claim date. We contacted the participant, who did agree and thought that he may have just not "written that down in his diary".

We have no reason to believe there were irregularities regarding the services provided to the individuals we were unable to contact.

Based on the results of our confirmation activity, we conclude that provider services reported on the BCBSMT system are actually being rendered.

No exceptions were noted.

IV - ELIGIBILITY

The plan sponsors use various methods to report new entrants, changes and termination of coverage to BCBSMT. This section describes the methods employed and presents the results of the verification of eligibility for the 600 in our sample where a payment was made by BCBSMT.

STATE OF MONTANA

The State prepares and sends to BCBSMT a biweekly eligibility tape showing each individual to be covered for the coming month. BCBSMT runs this tape and compares it to the data for the prior month.

Eligibility Verification

Each of the State participants in our sample was researched on the State eligibility system to verify that the State's records indicated that coverage was in force on the date the services were rendered.

No exceptions were noted.

MONTANA UNIVERSITY SYSTEM

BCBSMT receives the enrollment data from each campus on a daily basis. BCBSMT then follows the same process as the State.

Eligibility Verification

Each of the MUS participants in our sample was researched at the applicable campus to verify that the BCBSMT's records indicated that coverage was in force on the date the services were rendered. MUS records confirmed that all participants in the sample were covered as of the date the services were rendered.

No exceptions were noted.

V - BCBSMT REIMBURSEMENT

The Plan Sponsors reimburse BCBSMT for claims paid on behalf of subscribers and their eligible dependents. BCBSMT credits the Plan Sponsors for overpaid claims once they are corrected.

The scope of our service included the measurement of the time required by the plan sponsors to reimburse BCBSMT for claims processed. The results of our test work is presented below.

The scope of our service also included the verification of overpayment credits and lost benefit checks. The results of our test work is also presented below.

REIMBURSEMENT PROCESSING TIME

BCBSMT submits invoices for reimbursement for claims paid during a certain period. The frequency of the invoices and the payment terms differ for each plan sponsor. Presented below is information regarding the contractual provision and the actual time required to reimburse BCBSMT based on records made available to us.

State of Montana

The State will bank wire transfer the requested amount within 48 hours of the receipt of a phone call from BCBSMT. BCBSMT then sends the State an invoice reflecting the amount requested.

We gathered invoices from January 1, 2000 through December 31, 2001 and measured the elapsed time between the phone call and the date payment was made by the State.

A total of 10 invoices were included in our review.

We noted that the state actually reimburses BCBSMT within 48 hours of the receipt of a phone call from BCBSMT. Therefore, the state reimburses BCBSMT before the receipt of the invoice. Upon receipt of the invoice from BCBSMT, the state compares the amount requested to the wire transfer confirmation.

We noted no exceptions when comparing the wire transfer amount to the invoice amount. The amount requested, by phone, from BCBSMT was paid within 48 hours of the phone call in all 10 cases.

Montana University System

MUS will bank wire transfer the amount within 48 hours of the receipt of the invoice.

We gathered invoices from January 1, 2000 through December 31, 2001 and measured the elapsed time between the receipt of the invoice and the date payment was made by MUS.

A total of 10 invoices were included in our review.

We noted no exceptions when comparing the wire transfer amount to the invoice amount. The amount requested, by phone, from BCBSMT was paid within 48 hours of the phone call in all 10 cases.

Refunds

Certain situations cause BCBSMT to receive refund checks. These refunds should be credited to the applicable participant and plan. We selected three refunds for each plan sponsor for testing.

We reviewed 10 refunds for each group. We traced the dollar amount refunded from a copy of the refund check to the "Detail Claims Report", in order to verify the group was credited the appropriate amount. The dollar amount refunded was then traced to the "Claims History Summary" in BCBSMT system.

No exceptions were noted.

Stop Pay and Reissued Checks

In some situations, checks are lost or destroyed before they can be cashed. In this event, BCBSMT will stop payment on the issued check and reissue a check.

We selected 10 reissued checks from each plan sponsor.

One reissue check, for the State, did not match the amount listed in the report (it was also for another subscriber ID). We believe this was a BCBSMT recording error. No other exceptions were noted.

VI - CLAIM PAYMENT TURNAROUND TIME

The purpose of this section is to present our analysis of the claim turnaround time information for each of the 600 claims in our sample.

Claim Processing Time

Claim processing time or turnaround time for this audit was measured from the "received date" as entered on the claim document (in the form of a claim number, which includes a Julian date as the received date) to the date the check was mailed to the participant or provider.

Results, by plan sponsor, are presented below.

State of Montana

For all 401 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	17
Median	7
Mode	7

BCBSMT informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

MUS

For all 199 claims in our sample, the turnaround time results are as follows:

Measure	Elapsed Days
Mean	15
Median	7
Mode	7

BCBSMT informed us that company policy for turnaround time is 7 day average for non-investigated claims and 21 day average for claims requiring investigation.

Further information for each of the plan sponsors is presented as **Exhibit B**.

VII - COST CONTAINMENT

Discussion regarding cost containment procedures utilized at BCBSMT is presented below.

CASE MANAGEMENT

A mandatory pre-admission notification provision is part of each plan sponsor's Plan provisions. The notification procedure is used to alert APS Healthcare Northwest, Inc. (the case management firm utilized by the plans) of potentially large claims which could be eligible for individual case management to reduce the magnitude of the claim.

ADMINISTRATIVE PROCEDURE

A significant percentage of physicians are "participating doctors" with the BCBSMT network. The Plan limits the allowable charges by the participating doctors to their contractual fee agreement with BCBSMT. This agreement also precludes participating doctors from charging the patient for the difference between the actual charge and the contractual charge. Charges by non-participating doctors are limited to 90 percent of the allowance for participating doctors.

SUBROGATION

All claims that indicate an accident and/or work related accidents are forwarded to the Subrogation Department. This Department then sets up the file and sends out a letter for details of the accident. Upon receipt of the letter, BCBSMT then sends the appropriate letter(s) in order to: (1) assert their subrogation right, (2) notify participant that the Third Party Liability coverage is primary to the plan, or (3) recover payments made related to a work related injury.

Subrogation recovery information by plan sponsor is presented below.

The State of Montana

The State's recovery information is detailed below.

Year	Auto/Medical	Subrogation	ITS (Blue Card)	Workers' Comp
1998: Recovery	($51,485.60)	$26,194.44	$13,210.73	($45,442.50)
Savings	175,922.90	31,828.04	0.00	134,190.50
1999: Recovery	(3,797.11)	36,972.67	12,718.12	50,960.27

Savings	71,130.31	25,816.17	0.00	83,304.64
2000: Recovery	18,143.31	21,858.78	13,988.66	37,802.43
Savings	70,975.74	33,217.41	114,068.58	0.00
2001: Recovery	(38,832.58)	73,850.84	5,736.33	79,115.95
Savings	127,987.48	40,491.34	0.00	185,835.91

MUS

MUS's recovery information is detailed below.

Year	Auto/Medical	Subrogation	ITS (Blue Card)	Workers' Comp
1998: Recovery	($3,631.51)	$24,281.90	$993.70	($21,327.55)
Savings	33,767.38	3,266.86	0.00	15,196.59
1999: Recovery	40,416.77	17,157.70	615.30	47,949.71
Savings	36,593.54	4,952.87	0.00	31,564.47
2000: Recovery	5,078.15	11,888.61	1,315.50	17,757.57
Savings	13,224.94	9,279.09	0.00	98,726.63
2001: Recovery	(7,030.39)	19,548.71	628.00	11,046.76
Savings	40,508.62	9,642.57	0.00	27,253.91

FRAUD INVESTIGATION

An active fraud investigation function is an effective deterrent to those who may consider such activities.

BCBSMT has developed a fraud investigation program, which includes the following:

- Fraud Awareness Program for all claim processors and customer service representatives.
- EOBs are sent to the patient for every claim submitted to BCBSMT for processing.

- BCBSMT has developed a web site, for which participants may access to report possible fraud.

- BCBSMT had established a fraud hotline, which is indicated on each EOB received by the member. The web site address is listed on every EOB the member receives.

- Every out-of-state, non-network doctor is researched for licensure information from the appropriate State Board of Physicians by the BCBS plan where the provider is licensed.

- The BCBSMT claim system has the ability to flag providers that have been identified as having questionable billing practices.

- BCBSMT became a corporate member of the National Health Care Anti-Fraud Association (NHCAA) in 2001. NHCAA membership is comprised of numerous private and public sector organizations and individuals including various law enforcement agencies and 25 individual Blue Cross Blue Shield plans.

- BCBSMT developed a new corporate fraud awareness program in 2001, and training of employees from the Member Services and Support area began in the fall of 2001.

Recoveries

Recovery information for the years 1998, 1999, 2000 and 2001 for all BCBSMT's book of business is presented below.

Year	Recovery
1998	$143,994.78
1999	$ 84,107.10
2000	$ 96,986.00
2001	$270,936.00

The above recovery dollars is based on actual recoveries, rather than projected savings.

Based on our review we conclude that the investigative procedures and staff training are further advanced than many administrators.

VIII - LOGIC AND OTHER TEST RESULTS

This section presents the results of test claims submitted to the BCBSMT claim system as a method of assessing the system's ability to identify inappropriate transactions. The tests and the results are discussed below.

To protect against issuance of actual check payments and contamination of member history, a test cycle was used for all test claims.

Duplicate Claims

The claim system contains a series of edits designed to identify duplicate claims. If an exact match with a previously processed claim, the claim is rejected as a duplicate.

To test the system's duplicate claim logic, we selected four previously processed claims. Each claim was altered as follows:

- Change the diagnosis.
- Change the billed amount.
- Change the provider code.

This resulted in twelve separate resubmissions, each with one of the above changes made. In each case, the system correctly identified the fictitious resubmissions as a duplicate claim.

Finally, we submitted 10 previously processed claims.

The system correctly identified the 10 claims as duplicates.

Overcharging By Providers

BCBSMT has developed fee allowances for professional services. Our review confirmed that the system will correctly calculate the allowance.

We submitted five fictitious test claims where the provider's fee exceeded the allowance. The claim processing system correctly identified all five overcharges and reduced the allowance to agree with the appropriate amount.

Unnecessary Physician Services

The claim system has several edits designed to identify potentially unnecessary physician services. These edits involve matching diagnosis codes to procedure codes, monitoring the frequency of service and comparing the procedure to the patient's sex. In addition, claims from providers with a history of abuses or suspect billing practices are suspended for further evaluation prior to payment.

As part of our test work, we prepared and submitted five fictitious test claims where the patient's sex was not consistent with the procedure/diagnosis. All five of the claims were correctly identified as inconsistent with the patient's sex.

We also submitted five test claims involving fictitious type of service codes. All five claims were correctly suspended as containing invalid codes.

Other Test Claims

Additional test claims processed are discussed below.

Terminated Employees and Dependents

We submitted ten fictitious claims (five for employees and five for dependents) for individuals whose coverage had terminated. Each date of service followed the date coverage terminated. The system correctly rejected all 10 of the claims as claims incurred following termination of coverage.

Fraudulent Providers

We submitted five test claims from a fictitious provider. The test claims were entered. However, according to procedures, when an invalid provider number was entered, the processor would forward the claim to the Provider Maintenance Department where further investigation is performed.

Coordination of Benefits

Five fictitious claims were prepared for individuals whose history file indicated that other insurance coverage was present. All five of these claims were suspended for COB information.

SUMMARY

Based on our test results, we conclude that the BCBSMT system is effective in identifying erroneous claims.

Test Claim Summary

The findings from the fictitious claim testing are summarized as **Exhibit C** attached to this report.

IX - PRIOR AUDIT RECOMMENDATIONS

The most recently completed audit for the State of Montana and Montana University System (The Montana Power Company was included), prior to this audit, was performed for the period January 1, 1998 through December 31, 1999.

The report for that audit, issued in November, 2000, contained the following recommendations:

COORDINATION OF BENEFITS

The recommendation stated that BCBSMT review all claims where the participant is covered under more than one BCBSMT plan and return payments in excess of the BCBSMT allowable amount to the Plan Sponsors.

Comment

BCBSMT stated that they will be changing their procedures, to not exceed the BCBSMT allowable amounts, for these types of COB claims. However, since they are considered significant system and contractual changes they will not be able to implement these changes until July 1, 2002.

DUPLICATE CLAIM

The recommendation stated that in the event that Medicare is primary and BCBSMT processes secondary, the claim should not be processed on two different benefit levels, which causes a duplication of benefits. We also stated that BCBSMT discuss this procedure with the State, MUS and MPC. In the event of the State, MUS and MPC disagree, BCBSMT should review all claims affected by this procedure and refund overpayments to the Plan Sponsors and adjust deductible and/or coinsurance accumulators.

Comment

BCBSMT stated that all claims affected by this duplication of benefits have been adjusted and refunds, if applicable, were reimbursed to the plan sponsors.

HANDLING FEES

The recommendation stated that BCBSMT review their policy of paying for handling fees with the State, MUS and MPC.

Comment

BCBSMT stated that they did discuss this with the plan sponsors and the plan sponsors feel that charging separately for handling fees is unbundling of charges and therefore should be considered ineligible.

BCBSMT implemented a change in their guidelines, as of April 14, 2000, to discontinue paying any handling fees.

TOBACCO USE DISORDER

The recommendation stated that BCBSMT should review their policy as it relates denying charges for tobacco use disorder.

Comment

BCBSMT stated that they discussed this situation with The Montana Power Company and all charges for tobacco use disorder should have been denied.

REFUNDS AND REISSUED CHECKS

The recommendation stated that BCBSMT review their system and make the appropriate changes to better identify reissued checks.

The recommendation also stated that BCBSMT would benefit from maintaining a refund and stop pay/reissue log. The Internal Audit Department could then use this to help identify any patterns with participants and/or providers.

Comment

BCBSMT implemented a program to identify reissued checks. We confirmed this through our test work.

However, the Internal Audit Department at BCBSMT does not maintain, or allowed access to, a refund and stop pay/reissue log, in order to help identify any patterns with participants and/or providers. We continue to maintain that this would be an effective tool in their auditing procedures.

X - CONCLUSIONS AND RECOMMENDATIONS

We performed our audit based on the services requested and agreed upon in our audit contract. Claim payment accuracy was determined based upon the provisions in the documents describing the medical care and dental care benefits plan of each plan sponsor.

The purpose of this section of our report is to present recommendations which we believe to be appropriate for the plan. Each recommendation is presented below with a brief description of its purpose and intended result.

LIFETIME MAXIMUM

During our test work regarding the calculation of the State's $1,000,000 lifetime maximum provision, we noted that BCBSMT must manually monitor the accumulation of benefits of both system claims and archived claims for participants with high utilization.

We believe the manual monitoring procedure may result in inaccurate processing of claims in excess of the lifetime benefit. Therefore, we recommend BCBSMT establish a program that automatically accumulates the benefits of both archived claims and system claims.

OFFICE VISIT COPAYS

During our test work of the sample claims, we identified a situation where a State employee went to two different doctors in one day. BCBSMT only applied one $15.00 co-pay, which is their policy on all their lines of business. We believe this was not in accordance with the State's plan provision for a $15.00 co-pay per office visit.

We requested BCBSMT to verify that the State was in agreement with this procedure. The State was not in agreement and was not aware that this procedure was in place at BCBSMT.

We believe BCBSMT should reimburse, to the State, the overpayments caused by this procedure.

LARGE CASE MANAGEMENT

During our audit of the 600 sample claims, we identified two high dollar claims that were not subject to Large Case Management. However, other claims for the two patients were subject to Large Case Management.

We believe earlier intervention with Large Case Management could have provided discounts on these large hospital bills. We recommend BCBSMT encourage earlier intervention

on these high dollar claims.

"PIGGYBACK" CLAIMS

BCBSMT processes some preventive claims as "piggyback", meaning the claim will process on the preventive level first and if the charges exceed the preventive maximum, the claim will then process on the medical level where deductible and coinsurance limits are applied.

We believe this process contradicts the preventive limits outlined in the plan documents.

We recommend BCBSMT discuss this procedure with the State and MUS. In the event, of the State and MUS disagree, we believe BCBSMT should review all claims affected by this procedure and refund overpayments to the Plan Sponsors and adjust deductible and/or coinsurance accumulators.

Exhibit A

STATE OF MONTANA AND MONTANA UNIVERSITY SYSTEM
2000 - 2001 CLAIM AUDIT
SUMMARY OF FINDINGS

GROUP	CLAIM #	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	DESCRIPTION
STATE	10059351740	52.00	37.00	15.00	Patient had seen two different doctors in the same day. BCBSMT only applied one $15 co-pay according to their policy. The State plan requires a co-pay to be applied for every office visit.
STATE	50263001000	120,945.96	94,533.03	26,412.93	Claim was not paid according to the large case management contract.
STATE	60019104470	69,043.85	68,874.01	169.84	"Split" claim incorrectly, causing the discount to not be applied. Claim was adjusted prior to the audit.
MUS	11099103480	6,695.13	6,691.98	3.15	Semi-private room charge was miscalculated. Should have been $862x7days=$6,034 then 10% discount.
STATE	21097720760	25.10	30.01	(4.91)	Data entry error. Units of service were not entered correctly causing the underpayment.
MUS	01017001130	617.63	613.89	33.75	Data entry error, causing incorrect benefits to be applied.
STATE	00157513200	4,423.84	4,381.02	(42.82)	Medicare COB error. Medicare allowable incorrectly entered, causing the underpayment.

Exhibit B

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
BLUE CROSS BLUE SHIELD OF MONTANA
CLAIM PAYMENT TIME

Information regarding the time required for BCBSMT to pay following the the receipt of a claim.

MEASURE	STATE	MUS
Mean	17.31	14.94
Median	7	7
Mode	7	7

Percent Paid From Date Of Receipt Of Claim For State

Day	# of Claims	% of Claims
1	16	3.99%
2	23	5.74%
3	36	8.98%
4	38	9.48%
5	17	4.24%
6	33	8.23%
7	47	11.72%
8	21	5.24%
9	10	2.49%
10	15	3.74%
11	9	2.24%
12	4	1.00%
13	8	2.00%
14	8	2.00%
15	18	4.49%
16	1	0.25%
17	6	1.50%
18	7	1.75%
19	4	1.00%
20	4	1.00%
21	8	2.00%
22	4	1.00%
23	0	0.00%
24	2	0.50%
25	4	1.00%
26	3	0.75%
27	4	1.00%
28	4	1.00%
29	0	0.00%
30	4	1.00%
30 plus	43	10.72%
Total	401	100.00%

Percent Paid From Date Of Receipt Of Claim For MUS

Day	# of Claims	% of Claims
1	14	7.04%
2	13	6.53%
3	16	8.04%
4	24	12.06%
5	14	7.04%
6	15	7.54%
7	25	12.56%
8	10	5.03%
9	5	2.51%
10	14	7.04%
11	5	2.51%
12	3	1.51%
13	2	1.01%
14	1	0.50%
15	2	1.01%
16	1	0.50%
17	3	1.51%
18	3	1.51%
19 thru 20	0	0.00%
21	3	1.51%
22	0	0.00%
23	1	0.50%
24	2	1.01%
25	2	1.01%
26 thru 27	0	0.00%
28	2	1.01%
29	0	0.00%
30	1	0.50%
30 plus	18	9.05%
Total	199	100.00%

Exhibit C

STATE OF MONTANA EMPLOYEE BENEFIT PLAN
BLUE CROSS BLUE SHIELD OF MONTANA
RESULTS OF SYSTEM TESTS

	RESULTS		
TEST	**PASS**	**FAIL**	**COMMENT**
Duplicate Claims Tests	All 10		
Logic Claims Tests			
Change Diagnosis	4		
Change Billed Amount	4		
Change Provider Code	4		
Other Claims Tests			
Terminated Member	All 5		
Terminated Dependent	All 5		
Fictitious Provider	All 5		
Fictitious Service Code	All 5		
COB Claims	All 5		
Test/Allowable Data	All 5		
Inconsistent With Sex	All 5		

Blue Cross Blue Shield of Montana

An Independent Licensee of the Blue Cross and Blue Shield Association

550 N. Park Avenue
P.O. Box 4309
Helena, Montana 59604
(406)444-8200

Customer Information Line:
1-800-447-7828

April 19, 2002

EXHIBIT D

MARIE POLLOCK
WOLCOTT & ASSOCIATES, INC
SUITE 103
10997 GRANADA LANE
OVERLAND PARK KS 66211

RE: Montana University System and State of Montana Audit

Dear Marie:

This letter is in acknowledgement of the draft report for the Montana University System and State of Montana audit recently completed for the audit period January 1, 2000 through December 31, 2001.

This letter includes Blue Cross Blue Shield of Montana's (BCBSMT) response to the Summary of Findings in Exhibit A and Conclusions and Recommendations. I have also included some additional comments regarding Refunds and Reissued Checks (IX-2).

Exhibit A (#1) "Patient had seen two different doctors in the same day. BCBSMT only applied one $15 co-pay according to their policy. The State plan requires a co-pay to be applied for every office visit."

Comment: BCBSMT agrees with this finding.

Exhibit A (#2) "Claim was not paid according to the large case management Contract."

Comment: BCBSMT agrees with this finding. This claim was adjusted to reflect the correct payment amount. The adjustment finalized on 03/25/02.

Exhibit A (#3) "Split claim incorrectly, causing the discount to not be applied. Claim was adjusted prior to audit."

Comment: BCBSMT agrees with this finding.

Exhibit A (#4) "Semi-private room charge was miscalculated. Should have been $862x7days+$6,034 then 10% discount."

Comment: BCBSMT agrees with this finding.

Exhibit A (#5) "Data entry error. Units of service were not entered correctly causing the underpayment."

Comment: BCBSMT agrees with this finding, however, this error was made by an adjustment technician, not data entry. The adjustment done on this claim to correct the units of service and payment finalized 03/22/02.

Exhibit A (#6) "Data entry error, causing incorrect benefits to be applied."

Comment: BCBSMT agrees with this finding. The adjustment correcting payment for this claim finalized 03/18/02.

Exhibit A (#7) "Medicare COB error. Medicare allowable incorrectly entered, causing the underpayment."

Comment: BCBSMT agrees with this finding. The adjustment on this claim, to correct payment, finalized 03/25/02.

X - CONCLUSIONS AND RECOMMENDATIONS

(X - 1) **LIFETIME MAXIMUM**

"During our test work regarding the calculation of the State's $1,000,000 lifetime maximum provision, we noted that BCBSMT must manually monitor the accumulation of benefits for both system claims and archived claims for participants with high utilization.

We believe the manual monitoring procedure may result in inaccurate processing of claims in excess of the lifetime benefit. Therefore, we recommend BCBSMT establish a program that automatically accumulates the benefits of both archived claims and system claims."

Comments: BCBSMT is notified by two external sources, the State of Montana and APS/VRI, when a particular member's utilization becomes substantially high. Internally we also have a Dedicated Service

Team for the State of Montana and the Special Accounts Liaison who monitor utilization.
Currently BCBSMT runs an archive report once we receive notification from one of the sources for high utilization on a member. A "mock" claim is manually entered for the total dollar amount paid on archived claims. The subscriber ID, dependent number and name are then entered into a "parm" which tells the system not to archive any claims for this member.
BCBSMT would like to propose that we run a report once a month for the State of Montana subscribers. The report would pull any subscriber/member who has accumulated $900,000 (or an amount specified by the State of Montana) in benefit payments, including current history and archived claims. From the report we could enter the "mock" claim for the archived claims and enter that subscriber/member into the archive "parm" or put them on stop to ensure the benefit maximum is not exceeded.
BCBSMT will have the Marketing representative contact the State of Montana to see if they find our proposed changes acceptable.

(X - 1) **OFFICE VISIT COPAYS**

"During our test work of the sample claims, we identified a situation where a State employee went to two different doctors in one day. BCBSMT only applied one $15.00 co-pay, which is their policy on all their lines of business. We believe this was not in accordance with the State's plan provision for a $15.00 co-pay per office visit.

We requested BCBSMT to verify that the State was in agreement with this procedure. The State was not in agreement and was not aware that this procedure was in place at BCBSMT.

We believe BCBSMT should reimburse, to the State, the overpayments caused by this procedure."

Comments: BCBSMT will be running a report to capture the total number of claims that this occurred on. The representative in our Marketing Department will discuss this with the State of Montana in order to determine if they would like us to adjust these claims. We will correct the system coding to apply the $15 copay on all future claims.

(X - 1) **LARGE CASE MANAGEMENT**

"During our audit of the 600 sample claims, we identified two high dollar claims that were not subject to Large Case Management. However, other claims for the two patients were subject to Large Case Management.

We believe earlier intervention with Large Case Management could have provided discounts on these large hospital bills. We recommend BCBSMT encourage earlier intervention on these high dollar claims."

Comments: The University System and the State of Montana contract directly with APS/VRI, not BCBSMT, for large case management. It is the responsibility of Montana University System or State of Montana to contact APS/VRI for assessment of large case management. BCBSMT then processes claims per the contracted benefits once they have received them from APS/VRI.

(X - 2) "**PIGGYBACK" CLAIMS**

"BCBSMT processes some preventative claims as "piggyback", meaning the claim will process on the preventative level first and if the charges exceed the preventative maximum, the claim will then process on the medical level where deductible and coinsurance limits are applied.

We believe this process contradicts the preventative limits outlined in the plan documents."

Comments: The maximum benefit payable on the preventative benefit level is not exceeded. Any charges exceeding the preventative maximum are processed on the medical level, giving the member the best benefit.
BCBSMT will have the Marketing representative present this issue to the Montana University System and the State of Montana to ensure they know we are processing these claims in this manner and that this is acceptable to them.

V - BCBSMT REIMBURSEMENT

(V - 2) **Stop Pay and Reissued Checks**

"In some situations, checks are lost or destroyed before they can be cashed. In this event, BCBSMT will stop payment on the issued check and reissue a check.

We selected 10 reissued checks from each plan sponsor.

One reissue check for the State, did not match the amount listed in the report (it was also for another subscriber ID). We believe this was a BCBSMT recording error. No other exceptions were noted."

Comments: BCBSMT had a problem with the resequencing process in check reconciliation for this date. The recovery was completed after the incorrect check numbers were posted to disbursements for inquiry (SCL). The check numbers are now correct. BCBSMT has

implemented a new process to alleviate this problem. If the resequencing job fails, the posting of reissue information to disbursements cannot run until the previous job failure is fixed.

IX - PRIOR AUDIT RECOMMENDATIONS

(IX - 2) **REFUNDS AND REISSUED CHECKS**

"The recommendation stated that BCBSMT review their system and make the appropriate changes to better identify reissued checks.

The recommendation also stated that BCBSMT would benefit from maintaining a refund and stop pay/reissue log. The Internal Audit Department could then use this to help identify any patterns with participants and/or providers.

Comment

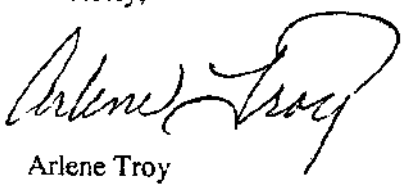
BCBSMT implemented a program to identify reissued checks. We confirmed this through our test work.

However, the Internal Audit Department at BCBSMT does not maintain, or allowed access to, a refund and stop pay/reissue log, in order to help identify any patterns with participants and/or providers. We continue to maintain that this would be an effective tool in their auditing procedures."

Comment: A new database was created in Finance, at Internal Audit's request, which can be used to identify reissued checks. This was done per the recommendation in the last audit (1998-1999) conducted in 2000. Refunds are identified through a different database. The new database was used to pull the sample of reissued checks given to the auditors this year. As of the present date, Internal Audit has not used this database as part of an internal audit, due to other priorities. BCBSMT agrees that this will be a useful tool in identifying evolving patterns with participants and/or providers.

Thank you for the opportunity to comment on this audit report. If your have any questions or comments, please contact me at (406) 447-8730.

Sincerely,



Arlene Troy
Internal Audit
Blue Cross and Blue Shield of Montana

EXHIBIT E

DEPARTMENT OF ADMINISTRATION
STATE PERSONNEL DIVISION
STATE OF MONTANA

Mitchell Building, Room 130
PO Box 200127
Helena Montana 59620-0127

(406) 444-3871
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http://discoveringmontana.com/doa/spd/csa/

April 23, 2002

Marie Pollock, Vice President
Wolcott & Associates, Inc.
10977 Granada Lane, Suite 103
Overland Park, Kansas 66211

Dear Ms. Pollock:

We received your draft report on the State of Montana Analysis and Evaluation of Claims Processing for the period January 1, 2000 through December 31, 2001, and we provide the following responses to your audit findings and recommendations.

Lifetime Maximum

RECOMMENDATION: Blue Cross and Blue Shield of Montana's (BCBSMT) procedure for calculating the State's $1,000,000 lifetime maximum provision is based on manually monitoring the accumulation of benefits of both system claims and archived claims for participants with high utilization. The manual monitoring procedure may result in inaccurate processing of claims in excess of the lifetime benefit. Therefore, BCBSMT should establish a program that automatically accumulates the benefits of both the archived claims and system claims.

RESPONSE: We concur with the recommendation that BCBSMT establish a program that automatically accumulates the benefits of both archived claims and system claims. In order to properly administer the lifetime maximum, it is necessary to have complete and timely information regarding member's total accumulation. We believe BCBSMT should develop a system to automatically accumulate both archived and system claims and provide that information to the State as needed.

Office Visit Copays

RECOMMENDATION: In accordance with the policy for BCBSMT on all their lines of business, BCBSMT applied one $15.00 co-pay for an employee who visited two different doctors in one day. This is not in accordance with the State's plan which requires application of a $15.00 co-pay per office visit. BCBSMT should reimburse, to the State, the overpayments caused by this procedure.

RESPONSE: We concur with the recommendation.

Large Case Management

RECOMMENDATION: Two high dollar claims were not subject to Large Case Management. Other claims for the two patients were subject to Large Case Management. Earlier intervention with Large Case Management

could have provided discounts on these large hospital bills. BCBSMT should encourage earlier intervention on these high dollar claims.

RESPONSE: The State contracts with APS/VRI to provide individual case management services. Referral for case management review may come from a State Plan member, family member, provider, or a representative of the Plan. Determination of suitability for individual case management services is made by APS/VRI. The criteria for determination of suitability include savings potential in light of Plan maximums, day or dollar limits in the Plan, potential medical cost involved in the case, available Plan benefits and complicating factors such as family or personal circumstances and resources. The case management plan may be implemented under existing Plan benefits if applicable, or approval of extra-contractual benefits may be discussed with the State Plan representatives if necessary to achieve optimal results under the case management plan. BCBSMT processes the claims per the contractual benefit designation prescribed in the case management plan.

"Piggyback" Claims

RECOMMENDATION: BCBSMT processes some preventive claims through a process that allows initial charges to process on the preventive level first, exhausting that benefit, and then if charges exceed the preventive maximum, the balance of the claim processes on the medical level where deductible and coinsurance limits are applied. BCBSMT should discuss this procedure with the State. If the State disagrees with this processing procedure, BCBSMT should review all claims affected by this procedure, refund overpayments to the State, and adjust deductible and/or coinsurance accumulators.

RESPONSE: We concur with the recommendation.

Thank you for providing us with the opportunity to respond to the recommendations.

Sincerely,

Connie Welsh

Connie Welsh, Chief
Employee Benefits Bureau

MONTANA UNIVERSITY SYSTEM
Office of the Commissioner of Higher Education

2500 Broadway ◊ PO Box 203101 ◊ Helena, Montana 59620-3101 ◊ (406)444-6570 ◊ FAX (406)444-1469

EXHIBIT F

April 23, 2002

Mr. Brian Wyman
Wolcott & Associates, Inc
Suite 103
10977 Granada Lane
Overland Park Kansas 66211

Dear Mr. Wyman:

Thank you for the opportunity to respond to your audit of the Montana University System employee group insurance plan as administered by Blue Cross Blue Shield of Montana. Overall, your audit indicates that BCBSMT is doing a good job of administering the MUS health plan. Below is my response to your recommendation that requires Montana University System follow-up.

Recommendation: PIGGYBACK CLAIMS We recommend BCBSMT discuss this procedure with the state and MUS. In the event the State and MUS disagree, we believe BCBSMT should review all claims affected by this procedure and refund overpayments to the Plan Sponsors and adjust deductible and/or coinsurance accumulators.

RESPONSE: The University System concurs with this recommendation and will review this procedure with BCBSMT.

Thank you for the effort you and your staff put in on this audit.

Sincerely,

Glen D. Leavitt
Director of Benefits